North Carolina Industrial Commission

IC File #_____

Emp. Code #_____

Carrier Code #_____

Carrier File #_____

DENIAL OF WORKERS' COMPENSATION CLAIM (G.S. §97-18(c) AND G.S. §97-18(d))

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act Employer FEIN _____

Employee's Name			Employer's Name		( ) - Telephone Number
Address			Employer's Address	City	State Zip
City	State	Zip	Insurance Carrier	Policy Number	
( ) - Home Telephone	( ) - Work Telephone		Carrier's Address	City	State Zip
- - Social Security Number	☐ M ☐ F Sex	/ / Date of Birth	( ) - Carrier's Telephone Number	( ) - Fax Number	
Date of Injury:					

TO EMPLOYEE (TO DEPENDENT(S) OR NEXT OF KIN IN CASE OF DEATH):

This is to inform you that the claim for the
☐ injury on _____, or
☐ occupational disease as of _____, or
☐ death on _____

is **DENIED** for the following reasons:

_____ / /

SIGNATURE EMPLOYER OR CARRIER/ADMINISTRATOR **TITLE** **DATE**

Employer/Insurance Carrier must provide a detailed statement of the grounds for denying compensability of the claim or liability for the claim where payments have previously been made without prejudice under N.C. Gen. Stat. § 97-18(d). Failure to specify a particular ground may preclude asserting certain defenses at a later date pursuant to N.C. Gen. Stat. § 97-18(f).

Employee: If you disagree with this denial, you are entitled to request a hearing by submitting a Form 33. If you need assistance you may contact the Industrial Commission at the address below or telephone the Industrial Commission at (800) 688-8349.

Employer: A copy of this form shall be sent to the employee and employee's attorney of record, if any, and all known health care providers which have submitted bills to the employer/carrier. The original of this form shall be sent to the Industrial Commission at the address below.

MAIL TO: **NCIC - CLAIMS SECTION**
4335 MAIL SERVICE CENTER
RALEIGH, NC 27699-4335
TELEPHONE: (919) 807-2502
OMBUDSMAN: (800) 688-8349

FORM 61